Student Name_____

Medina County Career Center
General Medical Action Plan (MAP)

Child's picture

Student's Name _____
Date of birth _____ **Program** _____
Age _____ **Grade**_____ **School Year**_____

Page two of this MAP is to be signed and dated by the treating physician or licensed health care provider & by a parent/guardian. Without signatures this MAP is not valid. All medical supplies are to be provided by the family.

Bus # Driver: Transportation Office Use ONLY if needed
Route # Medical File

CONTACT INFORMATION

		Call First	**Try Second**
Parent/ Guardian:	Name:	_____	_____
	Relationship:	_____	_____
Phone:	Home:	_____	_____
	Cell:	_____	_____
	Work:	_____	_____

Call Third (If a parent/guardian cannot be reached)
Name: _____ Relationship: _____
Address: _____ Phone: _____

DIAGNOSIS

SIGNS & SYMPTOMS

1.

2.

3.

IF SYMPTOMS OCCUR, DO THE FOLLOWING

ADDITIONAL NOTES / INSTRUCTIONS

If prescription medication is to be used at school for the above condition, a "Authorization for the Administration of Prescription Medication By School Personnnel" will need to be completed, signed and dated by the physician/licensed prescriber AND a parent/guardian. If over the counter medication is to be used at school for the above condition, a "Authorization for the Administration of Over-The-Counter Medication By School Personnel will need to be completed, signed and dated by the parent/guardian.

Physician name _____ **Phone** _____ **Fax** _____
(Or treating health care professional)

SIGNATURE _____ **Date** _____

I agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to use my child's picture on this plan (if I did not supply a photo) and for staff to contact the treating health care professional for clarification of this plan, if needed.

Parent/Guardian name _____

PARENT SIGNATURE _____ **Date** _____

Melanie Queberg RN, BSN

MEDINA COUNTY CAREER CENTER

Authorization for the Administration of Over-The-Counter Medication by School Personnel

Student Name _____ Date of Birth _____

Address _____

Student's Program _____ Student's Instructor _____ Grade _____

PARENT/ GUARDIAN SECTION

We the undersigned request that the specified over-the-counter medication be administered to our child. We understand that the administration of this medication will be done under the supervision of a member of the school staff.

We further understand that the school personnel are not legally obligated to administer medication to any child. Therefore, we agree that the school district and its employees are free from any and all responsibility for the results of such medication or the manner in which it is administered.

We will notify the school immediately if we change or terminate the use of this medication for any reason.

Signature of Parent _____ Date _____

Home Phone Number _____ Work Phone Number _____

Medication must be provided in the original container (bottle). The dosage from the parent cannot exceed the dosage on the label.

Diagnosis for which medication is prescribed _____

Medication _____ Strength _____ Dose _____

Time Medication is to be Taken _____ Administration Start Date _____ Cease Date _____

Instructions or precautions, including possible side effects and storage:

_____

_____

_____

_____

Melonie Queberg RN, BSN

MEDINA COUNTY CAREER CENTER

Authorization for the Administration of Prescription Medication By School Personnel

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by medically untrained personnel, it is requested that the oral medication as indicated below be administered by school personnel.

Student Name _____ Date of Birth _____

School _____ Grade _____ Program _____

PARENT/ GUARDIAN SECTION

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. Both the parent (top section) and the licensed prescriber (bottom section) must complete this form.
2. Medication must be provided in the student's labeled prescription bottle. (The pharmacy may provide an extra bottle for long-term medication.) The prescription label must match the instructions from the prescriber. If it is a non-prescription medication, it must be in the original container.
3. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability ***foreseeable or unforeseeable*** for damages or injury resulting directly or indirectly from this authorization.
4. New forms must be submitted when there is a change in the original forms. (I.e. dose, time)

I request that medication be administered to my son/daughter according to the directions of the licensed prescriber in the following section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

Signature of Parent _____ Date _____

Daytime Phone _____

LICENSED PRESCRIBER SECTION

I verify that this medication must be taken by: _____
Name of Student

Diagnosis (reason) for which medication is prescribed _____

Medication _____ Strength _____ Dose _____

Time medication is to be taken _____ Administration start date _____ Cease Date _____

Instructions or precautions, including possible side effects & storage _____

Licensed prescriber signature _____ Date _____

Licensed prescriber printed name _____ Phone _____

Student to self- carry and self-administer Epi-Pen _____ Date _____ Physician Initials _____